STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MUI	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILE	DING	00	COMPL	
		155019	B. WING			09/16/	2014
	PROVIDER OR SUPPLIEI			1100 S	ADDRESS, CITY, STATE, ZIP CODE CURRY PK IINGTON, IN 47403		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	_	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE	ΓΕ	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	This visit was a State Licensur. This visit was in Investigation of IN00156243. Survey dates: 15, and 16, 20. Facility number Provider number AIM number: Survey Team: Melissa Gillis, Cheryl Mabry, Shelly Miller-V	a Recertification and e Survey. In conjunction with the of Complaint September 10, 11, 12, 14. ar: 000007 ber: 155019 100275040 RN-TC RN ice, RN on, RN (9/11, 9/12,		TAG	CROSS-REFERENCED TO THE APPROPRIAT	TE	
	Census payor Medicare: 13 Medicaid: 137						
	Other: 32 Total: 182						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000007

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 10/20/2014 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155019	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/16/2014
	PROVIDER OR SUPPLIER	1100 S	ADDRESS, CITY, STATE, ZIP CODE CURRY PK MINGTON, IN 47403	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 24, 2014; by Kimberly Perigo, RN.			
F000223 SS=A	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.			
	The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to ensure a resident was free from physical abuse in that a facility staff hit a resident on the arm. (Resident #7) (Certified Nursing Assistant (CNA)	F000223	It is with complete dedication that we rectify these cited area We strive daily to provide an environment that is safe and c is provided in a loving caring way. We respectfully submit the plan of correction as proof of compliance with State and	as. care

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D7PL11

Facility ID: 000007

If continuation sheet

Page 2 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DINC	00	COMPL	ETED
		155019	A. BUII B. WIN			09/16/	2014
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			CURRY PK		
GARDEN	I VILLA - BLOOMIN	IGTON			IINGTON, IN 47403		
						,	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	·		DATE
	#4)				Federal regulations, and per the laws that mandate the	ie	
					submission of this plan. We		
	Findings include:				respectfully request a desk		
					review/paper compliance for the	ne	
	The clinical red	cord for Resident #7			plan of correction submitted.		
	was reviewed	on 9/16/14 at 10:00			Please review the attached		
	a.m. Diagnos	es included, but were			documents with this plan of		
		atherosclerotic heart			correction, as evidence of		
	· ·	ral aneurysm rupture,			completion of this plan of correction and evidence of		
	· ·	art failure (CHF),			compliance. F223 1) What		
	•	•			corrective action(s) will be		
	dementia, diabetes, expressive aphasia, subarachnoid hemorrhage,				accomplished for those reside	nts	
	"	•			found to have been affected by	y	
	and seizure ac	uvity.			the deficient practice; Resid		
					#7 has been assessed with no		
		MDS (Minimum Data			injury or ill effect regarding this	6	
		ent, completed on			incident. Nursing and Social Services continues to monitor	to	
	8/14/14, indica	ted a BIMS (Brief			ensure resident remains free	io .	
	Interview Ment	al Status) score as 0.			from any abuse. CNA #4 was		
	Zero being cog	nitively impaired and			terminated. 2) How other	r	
	dependent on	nursing staff for daily			residents having the potential	to	
	decision makin	ig.			be affected by the same		
					deficient practice will be identified		
	Interview on 9/	16/14 at 10:15 a.m.,			and what corrective action(s) be taken; All residents have		
		#7 indicated when			potential to be affected by abu		
		andled her roughly,			Inservice was given regarding		
		nt was not able to be			abuse and reporting. All facilit	ty	
					staff were required to read and		
		en asked what roughly			sign the training provided. Se	e	
		eech was garbled			attached #1. 3) What		
	(expressive aphasia). Resident #7 was only able to answer in yes or no				measures will be put into place what systemic changes will be		
					made to ensure that the deficient		
	•	hen asked if Resident			practice does not recur; Upo		
	#7 was fine no	w indicated, "Yes."			hire, criminal history checks ar		
					drug testing are done, dement		
	Interview on 9/	16/14 at 10:25 a.m.,			and abuse training is		
	with CNA #3 (v	vitness) indicated, "Me			completed and at least annual	ly	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIIII	LDING	00	COMPL	ETED
		155019	A. BUII B. WIN			09/16/	2014
	ND 04 W		//11/		ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF F	PROVIDER OR SUPPLIE	К			CURRY PK		
GARDEN	N VILLA - BLOOMII	NGTON	_		MINGTON, IN 47403		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		dy" was helping			thereafter. All staff have bee		
		the bathroom. After			educated on what abuse look like and signs and symptoms		
		nt #7 on the toilet,			of staff burnout. The process		
	Resident #7 slapped CNA #4 and				shift report has changed to ha		
	CNA #4 slapp	ed the resident back on			licensed staff report informat		
		aid, " 'I slap back.' "			about resident change in		
		ident #7 up and she			condition to the CNAs and		
		was still struggling and			needed change in interventio		
		ner bicep [upper arm]			in their care. This process w	III be	
		esident #7 up against			a more proactive approach versus reactive.	4)	
	•	. •			How the corrective action(s)	,	
		id this three times. We			be monitored to ensure the		
	then got Resid	ient #1 to bea.			deficient practice will not recu	ır,	
					i.e., what quality assurance		
		6/14 at 9:00 a.m., of			program will be put into place		
	State Agency	Unusual Occurrence			In addition to our current Qu	ality	
	Report" provid	ed by the facility,			Assurance program,		
	indicated, "C	escription of Incident:			daily, administrative staff		
	NA [Nursing A	.ssistant / CNA #3],			will verify any changes in resident care interventions ha	ave	
		during peri-care with			been updated on CNA	440	
		CNA [CNA #4], was			assignment sheets and Care		
		tion taken: As soon as			Plans and communicated to f	loor	
	_	de CNA [CNA #4],			staff. Monthly this report will	be	
					included in the QA program.		
		out of facility. Resident			After 3 months, this process		
		for injuries, none			be reviewed for a scheule chaif no concerns found	ange	
		dent denies being			if no concerns found. ADDENDUM: While Garden	\/illa	
		g been hurt. POA			has a Chain of Command, in		
	l -	rney] and physician			circumstance, we train staff to		
	notified. Socia	al services notifiedit			follow the guidelines set forth		
	has been dete	rmined to terminate			the Elder Abuse Act stating		
	CNA [CNA #4] as [Resident #7] is not			:"Each employee, agent,		
		ime frames and staff			contractor, manager, owner,	or	
		s and [CNA #3] and			operator of this facility is	4	
		es do not match.			individually responsible to rep the reasonable suspicion of a		
		ent's living on unit have			crime against a resident"		
		_			education was clarified to exp		
	i neeu interview	ed and denies being			Saddation was diamica to exp		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155019	B. WIN			09/16/	2014
			D. (122		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			CURRY PK		
GARDEN	VILLA - BLOOMIN	IGTON			IINGTON, IN 47403		
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES	1	ID	·		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	treated roughly	*			to the staff that suspicion is all		
	l acatea roaging	, .			they need to report and the		
	CNA #4's report, dated 9/12/14, indicated, "Concerning [Resident #7], I helped new employee [CNA #3] get her out of her recliner and into the bathroom to change for bed.				investigation will be done to		
					determine outcome. All		
					allegations will be reported to		
					ISDH. This training includes a staff working all shifts. 5) B		
					staff working all shifts. 5) B what date the systemic change	,	
					will be completed. October		
		vas combative as			13, 2014		
	usual but no more than usual.						
	-	swatted at me, tried to					
		yee's hair. [Resident]					
	· -	vel movement] and					
	was not willing	to allow aid to clean					
	her. I took the	position of someone					
	who had worke	ed with [Resident #7]					
	and familiar wi	th her behavior, and					
	cleaned her bo	ottom and put her legs					
	up in bed and	exited the room never					
	to return the re	est of the evening or					
	following morn	ing."					
	CNA #3's repo	rt, no date, indicated,					
		w a employee when					
		got mad and slapped					
		irm, she [CNA #4]					
		ack on the arm and					
		ck.' Then when she					
		cleaning her bottom,					
		_					
	[Resident #7] started screaming and crying so she [CNA #4] kept shoving her [Resident #7] against the wall 3 times just to clean her."						
	i umes just to cit	can ner.					
	Administrator's report, dated 9/12/14,						
		•					
	maicated "Rec	eived a report of rough					

PRINTED: 10/20/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155019			LDING	NSTRUCTION 00	(X3) DATE COMPL 09/16/	ETED		
	F PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN 47403					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	care from [CN/wrote that a costapped and should be while providing #3] to not only happened but she proceeded chair as if it we #3] said the result was striking [CNA #3] barely strueno hit me the word the resident should me stand and walker and the [CNA #3] said me stand and walker and the [CNA #3] leaned pretended to word to complete the harsh, she [CNA #4] said [Resident] forward to get fighting. She [CNA #4]	A #3] this am. She -worker [CNA #4] noved [Resident #7] care. I asked [CNA						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D7PL11

Facility ID: 000007

If continuation sheet

Page 6 of 43

PRINTED: 10/20/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155019	A. BUILDING	00	COMPLETED 09/16/2014
		199018	B. WING		09/10/2014
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE CURRY PK	
GARDEN	I VILLA - BLOOMIN	GTON		MINGTON, IN 47403	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		d this am and gave a			
		e [CNA #4] indicated			
	she only was providing care and was not abusive[Resident #7] was assessed and talked too. She has				
		is unable to describe			
	1	CNA #4] and [CNA #3]			
		ng the same story			
	[CNA #4] was t	erminated to ensure			
	safety of the re	sident"			
		44.00			
	On 9/10/14 at	· · · · · · · · · · · · · · · · · · ·			
		provided the Abuse			
		gram, revised date			
	•	dicated the policy was tly being used by the			
		olicy indicated, "Policy			
		ir residents have the			
	right to be free				
	_	Interpretation and			
	, ,	n 1. Our facility is			
	committed to p	rotecting our residents			
	from abuse by	anyone including, but			
		limited to: facility			
		acility conducts			
		ground checks and			
	will not knowing				
		has been convicted of			
		cting, or mistreating			
	program provid	Our abuse prevention			
	, , ,	onducting employment			
		ecks. b. Mandated			
	_	ientation programs			
		ch topics as abuse			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D7PL11

Facility ID: 000007

If continuation sheet Page 7 of 43

PRINTED: 10/20/2014 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155019	,	LDING	NSTRUCTION 00	(X3) DATE COMPL 09/16/	ETED
	PROVIDER OR SUPPLIER		p. wii.	1100 S	DDRESS, CITY, STATE, ZIP CODE CURRY PK INGTON, IN 47403	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)	ATE	(X5) COMPLETION DATE
	of occurrences potential mistre Timely and tho all reports and These are differed Catastrophic reactions by a restimuli, such as I may be weeping complaints of able immediately aduty and a Concept behalf of the resident is protect abusive acts which investigated, such separating resident to assess While these in the initiated by the Administrator are should be notified begin the report Health,if no be the report will be Abuse Every be free from mis reporting by staff and/or the administrator the administrator are should be notified begin the report will be Abuse Every be free from mis reporting by staff and/or the administrator the administration and the report will be Abuse Every be free from mis reporting by staff and/or the administration and the report will be administration and the reporting by staff and/or the administration and the report will be Abuse Every be free from mis reporting by staff and/or the administration and the reporting by staff and/or the administration and the report will be Abuse Every be free from mis reporting by staff and/or the administration and the report will be Abuse Every be free from mis reporting by staff and/or the administration and the report will be Abuse Every be free from mis reporting by staff and/or the administration and the report will be Abuse Every be free from mis reporting by staff and/or the administration and the report will be Abuse Every be free from mis reporting by staff and or the report will be Abuse Every be free from mis reporting by staff and Abuse Every be free from mis reporting by staff and Abuse Every be free from mis reporting by staff and Abuse Every be free from mis reporting by staff and Abuse Every be free from mis reporting by staff and Abuse Every be free from mis reporting the report Every be free from mis reporting the report	and patterns of eatment/abusef. rough investigations of allegations of abuse ent types of abuse: etions-extraordinary sident over ordinary basic care. Response anger, agitation, Any use by a resident will addressed by the nurse on ern/Suggestion form on dent The staff will brecautions to assure the eted from any further let he report is being has staff suspension, ents or increased ial service will visit the staff nurse, the ad Director of Nursing dimmediately and will to the State Board of ordily injury has occurred esent within 24 hours, resident has the right to					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D7PL11

Facility ID: 000007

If continuation sheet

Page 8 of 43

PRINTED: 10/20/2014 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155019	A. BUILDING B. WING	00	COMPLETED 09/16/2014			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN 47403					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE			
	the investigati immediately"	on must be						
	3.1-27(a)(1)							
F000224 SS=D	RIATN The facility must d written policies an mistreatment, neg residents and mist property.	appropriation of resident		5004W: W 15 C				
	Based on intervi	ew and record review,	F000224	F224 It is the policy of Garden	10/13/2014			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D7PL11

Facility ID: 000007

If continuation sheet

Page 9 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULT	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	00	COMPL	ETED
		155019	A. BUILDI B. WING	INO		09/16/	2014
				TREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	t			CURRY PK		
GARDEN	I VILLA - BLOOMIN	IGTON			IINGTON, IN 47403		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	1	ΓAG			DATE
		to ensure that each			Villa to ensure that residents a free from mistreatment. Garde		
	resident was free from mistreatment for 1				Villa submits the following acti		
	of 1 resident rev	iewed for abuse.			as evidence of its commitment		
	(Resident #143, QMA #1, RN #3)				compliance with regulatory		
					requirements. 1) What		
	Findings include	•			corrective action(s) will be		
					accomplished for those reside		
	Dagidant #1421a	clinical record was			found to have been affected by	y	
					the deficient practice; The		
	reviewed on 9/12	•			QMA in question no longer provides care for Resident #14	12	
		ded, but were not limited			though Resident #143 has	1 5,	
	to: anxiety, depr	ession with suicidal			verbalized he welcomed the		
	ideation, atrial fi	brillation (irregular heart			interaction and care from		
	rhythm) hyperte	nsion, insomnia, and			QMA #1. A careplan was held		
	osteoarthritis.				with Resident #143 and the P0	OA.	
					Both agree that they feel that		
	The current MD	S (Minimum Data Set)			Resident #143 is safe in our ca	are	
					and have no concerns about his well being beyond his		
		d 7/30/14, indicated a			cognitive impairment. 2)		
	•	erview Mental Status)			How other residents having the	e l	
		hen 8-15 indicated			potential to be affected by the		
	Resident #143 w	as cognitively intact and			same deficient practice will be		
	interviewable.				identified and what corrective		
					action(s) will be taken All		
	On 9/11/14 at 8:	59 a.m., interview with			residents have the potential to		
		ndicated when asked has			affected by abuse. Inservice w given regarding abuse and	as	
		or anyone else here			reporting. All facility staff were		
	•	es, I don't know the			required to read and sign the		
		*			training provided. See attache	ed	
		A [QMA #1], but she			#1. 3) What measures will I	be	
	threw me against the wall while putting				put into place or what systemic		
	me in bed and being very rude. While				changes will be made to ensur		
	rolling me over she pushed me real hard				that the deficient practice does		
	against the pins in my back. I hollered				not recur Upon hire, criminal history checks and drug testing		
	•	hed against the pins. I			are done, dementia and abuse		
	•	the station and they didn't			training is completed and at le		
		moved her to the other			annually thereafter. All staff ha		
	i me mer, but mey	moved not to the other					

AND PLAN OF CORRECTION DISTRIBUCATION NUMBER 155019 SINGLE ADDRESS 100 SINGLE A	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
NAME OF PROVIDER OR SUPPLIER GARDEN VILLA - BLOOMINGTON (NA) ID SUMMARY STATUMENT OF DEPRETENCITS TAG SUMMARY STATUMENT OF DEPRETENCITS TAG SIde. She don't take care of me anymore." On 9/15/14 at 8:54 a.m. interview with QMA #1 indicated, when asked if she could tell me about the incident with [Name of Resident #143], "I don't really remember, but I had never had any problems with him before that day. I just remember him getting a little upset with me. I don't know if he was just having a bad day that day. We've been fine since." When asked if she still provided care for Resident #143, QMA #1 indicated, "I still check on him when I work. There is no problem. He see's me in the hall and speaks. This was not my regular hall." On 9/12/14 2:49 p.m., interview with the Administrator indicated, An Allegation of abuse came up, [Name of Resident #143], with QMA #1. I can not tell you dates, one morning I walked down the hall, Resident #143 said, a CNA [QMA #1 indicated; "T the legs hit the wall, and the resident was mad about it. The nurse saw it [Indicating, "H43] if QMA #1 indicated, "The legs hit the wall, and the resident was mad about it. The nurse saw it [Indicating, "H43] if QMA #1 did it intentionally Resident #143 report to form the case of the process of the BENDENCHION (XS) SWINGO 100 S CURRY PK BLOOMINGTON, IN 47403 STREET ADDRESS, CITY, STATE, 2IP CODE 1100 S CURRY PK BLOOMINGTON, IN 47403 PREFIX TAG SWINGO 100 S CURRY PK BLOOMINGTON, IN 47403 D PREFIX TAG PROPINE TO SUBSCRATION (XS) D PROPINE TAG SUBSCRATION (XS) D PROPI	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	DING	00	COMPL	ETED
STREET ADDRESS, CITY, STATE, ZIP CODE			155019				09/16/	2014
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On 9/12/14 2:49 p.m., interview with the Administrator indicated, An Allegation of abuse came up, [Name of Resident #143], with QMA #1. I can not tell you dates, one morning I walked down the hall, Resident #143 said, a CNA [QMA #1] bumped him into the wall. I immediately called the QMA #1. QMA #1 indicated, "The legs hit the wall, and the resident was mad about it. The nurse saw it [Indicating RN #3].' " When I asked [Name of Resident #143] if QMA #1 did it intentionally Resident #143 with the table of the province of the reasonable suspicion of a crime indicated. The floor staff. Monthly this report will be included in the QA program. After 3 months, this process will be reviewed for a scheule change if no concerns found. ADDENDUM: While Garden Villa has a Chain of Command, in this circumstance, we train staff to follow the guidelines set forth in the Elder Abuse Act stating: "Each employee, agent, contractor, manager, owner, or operator of this facility is individually responsible to report the reasonable suspicion of a crime		speaks. This wa	s not my regular nan.					
Administrator indicated, An Allegation of abuse came up, [Name of Resident #143], with QMA #1. I can not tell you dates, one morning I walked down the hall, Resident #143 said, a CNA [QMA #1] bumped him into the wall. I immediately called the QMA #1. QMA #1 indicated, "'The legs hit the wall, and the resident was mad about it. The nurse saw it [Indicating RN #3].' " When I asked [Name of Resident #143] if QMA #1 did it intentionally Resident #143 reasonable suspicion of a crime floor staff. Monthly this report will be included in the QA program. After 3 months, this process will be reviewed for a scheule change if no concerns found. ADDENDUM: While Garden Villa has a Chain of Command, in this circumstance, we train staff to follow the guidelines set forth in the Elder Abuse Act stating: "Each employee, agent, contractor, manager, owner, or operator of this facility is individually responsible to report the reasonable suspicion of a crime								
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#143], with QMA #1. I can not tell you dates, one morning I walked down the hall, Resident #143 said, a CNA [QMA #1] bumped him into the wall. I mediately called the QMA #1. QMA #1 indicated, "'The legs hit the wall, and the resident was mad about it. The nurse saw it [Indicating RN #3].' " When I asked [Name of Resident #143] if QMA #1 did it intentionally Resident #143 reasonable suspicion of a crime		Administrator in	dicated, An Allegation			be included in the QA program	١.	
if no concerns found. ADDENDUM: While Garden Villa has a Chain of Command, in this circumstance, we train staff to follow the guidelines set forth in the Elder Abuse Act stating: "Each employee, agent, contractor, nurse saw it [Indicating RN #3].' " When I asked [Name of Resident #143] if QMA #1 did it intentionally Resident #143 if no concerns found. ADDENDUM: While Garden Villa has a Chain of Command, in this circumstance, we train staff to follow the guidelines set forth in the Elder Abuse Act stating: "Each employee, agent, contractor, manager, owner, or operator of this facility is individually responsible to report the reasonable suspicion of a crime		of abuse came up	p, [Name of Resident					
dates, one morning I walked down the hall, Resident #143 said, a CNA [QMA #1] bumped him into the wall. I immediately called the QMA #1. QMA #1 indicated, "'The legs hit the wall, and the resident was mad about it. The nurse saw it [Indicating RN #3].' " When I asked [Name of Resident #143] if QMA #1 did it intentionally Resident #143		#143], with QM.	A #1. I can not tell you				nge	
hall, Resident #143 said, a CNA [QMA #1] bumped him into the wall. I immediately called the QMA #1. QMA #1 indicated, " 'The legs hit the wall, and the resident was mad about it. The nurse saw it [Indicating RN #3].' " When I asked [Name of Resident #143] if QMA #1 did it intentionally Resident #143 #1 did it intentionally Resident #143		3,	•					
#1] bumped him into the wall. I immediately called the QMA #1. QMA #1 indicated, "'The legs hit the wall, and the resident was mad about it. The nurse saw it [Indicating RN #3].' " When I asked [Name of Resident #143] if QMA #1 did it intentionally Resident #143 #1 did it intentionally Resident #143 #1 did it intentionally Resident #143		*	· ·					
immediately called the QMA #1. QMA #1 indicated, "'The legs hit the wall, and the resident was mad about it. The nurse saw it [Indicating RN #3].' " When I asked [Name of Resident #143] if QMA #1 did it intentionally Resident #143 #1 did it intentionally Resident #143 #2 we train staff to follow the guidelines set forth in the Elder Abuse Act stating: "Each employee, agent, contractor, manager, owner, or operator of this facility is individually responsible to report the reasonable suspicion of a crime							:e	
#1 indicated, "'The legs hit the wall, and the resident was mad about it. The nurse saw it [Indicating RN #3].' " When I asked [Name of Resident #143] if QMA #1 did it intentionally Resident #143 #143 #143 #1443 #1443 #1443 #1444 #1445 #144		- 1				· ·	,	
#1 indicated, "The legs hit the wall, and the resident was mad about it. The nurse saw it [Indicating RN #3].' " When I asked [Name of Resident #143] if QMA #1 did it intentionally Resident #143 #143 #1443 #1443 #1444 #1445 #144		,	•				er	
nurse saw it [Indicating RN #3].' " When I asked [Name of Resident #143] if QMA #1 did it intentionally Resident #143 #1 did it intentionally Resident #143 #2 did it intentionally Resident #143 #3 did it intentionally Resident #143 #4 did it intentionally Resident #143			-					
I asked [Name of Resident #143] if QMA #1 did it intentionally Resident #143 this facility is individually responsible to report the reasonable suspicion of a crime								
#1 did it intentionally Resident #143 responsible to report the reasonable suspicion of a crime		-	•				of	
#1 did it intentionally Resident #143 reasonable suspicion of a crime		I asked [Name o	f Resident #143] if QMA			-		
reasonable suspicion of a crime								
						against a resident" The	ic	
apologized to me.' " During continued education was clarified to explain		-	•				ain	
interview Resident #143 he did not feel to the staff that suspicion is all			_			•		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155019	B. WIN	G		09/16/	2014
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					CURRY PK		
GARDEN	I VILLA - BLOOMIN	IGTON		BLOOM	IINGTON, IN 47403		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE APPROPRI	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		l it on purpose and it was			they need to report and the investigation will be done to		
	an accident. I called the daughter and				determine outcome. All		
	_	that he has repeated that			allegations will be reported to the		
	• •	g speaking about the			ISDH. This training includes al		
	-	MA #1] he said that she			staff working all shifts. 5) By what date the systemic change		
		ed. The nurse that			will be completed. October		
		t it wasn't like that.			2014	,	
	_	as being provided, he was					
	already in bed.						
		32 a.m., interview with					
		ndicated when asked if he					
		MA #1 providing care					
	for him. "I don't	want her around me					
		want her around me, she					
		of me. She did come in					
	and did help me	do something after that					
	happened [indica	ating the incident], I can't					
	stand. No, I'm a	fraid. I think she was					
	mad at someone	and took it out on me."					
	So you do not w	ant QMA #1 to take care					
	of you anymore?	"No, she is not very					
	friendly. I like to	o kid and she is not that					
	type of person."	When asked do you					
	think QMA #1 w	vas intentionally mean to					
	you, Resident #1	43 indicated, "I don't					
	know, she was n	nean." Did you say					
	anything to her?	"Yes, I yelled."					
	On 9/16/14 at 11	:35 a.m., interview with					
	RN #3 indicated	, when asked if she could					
	tell me about the	incident with Resident					
	#143. "I was in	the hallway outside of					
		dicine. I heard him					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D7PL11

Facility ID: 000007

If co

If continuation sheet Page 12 of 43

PRINTED: 10/20/2014 FORM APPROVED OMB NO. 0938-0391

		(X2) M	(X2) MULTIPLE CONSTRUCTION			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155019	B. WIN	G		09/16/	/2014
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					CURRY PK		
GARDEN	N VILLA - BLOOMIN	IGTON		BLOOM	IINGTON, IN 47403		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	ame of QMA#1]. I really					
		was going on, but I					
		went in the room and he					
	_	he CNA [QMA #1]. He					
		s being rough with him					
	and he was mad.	What I heard was that					
	she was going to	have to roll him from					
	one side to other	to change him. I have					
	never seen her be	eing mean." Do you					
	recall what time	this incident happen?					
	"In in the morning	ng with her last bed					
	check around 5 of	or 6.[a.m.]." After that					
	happened what d	lid you do? "I don't					
	remember filing	a complaint cause he					
	_	remember talking to					
		ON] shortly after that."					
	-	e protocol? "You are					
		y the nurse on call. I want					
	1	but that's not right, I					
		ly. I don't consider that					
		was abusing her." Can					
	I -	lifferent types of abuse?					
		cally, emotionally." Did					
		igs happen to him?					
	I -	dent #143] "Not that I					
		Resident #143 at any time					
		ng this incident? "Not					
		here was plenty of room					
	for him not to hi	1 3					
	for him not to hi	t the Wall."					
	D. i. cuck	. A					
		e Agency Unusual					
	_	ort" dated October 8,					
	· ·	'Resident #143 is an					
	assist of 2 and fu	all body lift to transfer					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D7PL11

Facility ID: 000007

If continuation sheet Page 13 of 43

PRINTED: 10/20/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
		155019	B. WIN			09/16/	2014
	PROVIDER OR SUPPLIER			1100 S	DDRESS, CITY, STATE, ZIP CODE CURRY PK IINGTON, IN 47403	•	
	GARDEN VILLA - BLOOMINGTON			BLOOM	IINGTON, IN 47403		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.ΤΕ	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ent #143] has reported on					
		elt a [nurse] was rough					
	on 9/28/13Ad	•					
	_	vas found the staff					
		resident reported was					
		#1]. [Name of QMA #1]					
	"	Tame of Resident #143]					
		eakfast. [Name of					
	_	s an assist of 2 and full					
	1 *	fer. [Name of QMA #1]					
		ne of Resident #143]					
		e, because [Name of					
	_	a large man he is at					
		position. A nurse					
	_] was in the hall outside					
	_	ent #143] room and heard					
	_ `	#1] inform resident of					
		being done and asked					
	[Name of Reside	ent #143] to assist in					
		ame of RN #3] denied					
		ne or behavior on [Name					
	of QMA #1] par	t and [name of resident					
	_	mplaints or distress at					
	that time. [Name	e of QMA #1] denied					
	there being any p	problems with [Name of					
	Resident #143] a	at any time. [Name of					
	Resident #143] h	nas asked to withdraw the					
	complaint after v	voicing the initial					
	concern stating 't	there isn't any problems.					
	She's been nice t	o me since and I don't					
	want anyone to g	get in trouble].' "					
		e was documentation of a					
	phone conversat	ion with the DON and					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D7PL11

Facility ID: 000007

If continuation sheet

Page 14 of 43

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155019	A. BUII	LDING	NSTRUCTION 00	(X3) DATE COMPI 09/16	LETED
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	30, 10	
NAME OF F	PROVIDER OR SUPPLIER				CURRY PK		
GARDEN VILLA - BLOOMINGTON				BLOOM	IINGTON, IN 47403		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTI		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	COMPLETION DATE
1710		the incident with		1710	·		DATE
		hich took place on					
		as 7 days after the					
	incident occurred	•					
	On 9/16/14 at 12	:50 p.m., interview with					
	the DON indicat	ed, "The incident					
		otember 28, of 2013 and					
	=	ent] reported it on					
		his daughter was visiting					
		When asked when did					
	•	o you? "I talked to her					
	-	3] on 10/5/14. We made of QMA #1] was not					
	-	re did our investigation."					
	_	N #3] call you? "When					
	_	, because he didn't					
		ell out about the QMA					
		e [indicating RN #3]					
		until the 5th when I					
	called her. [Nan	ne of Resident #143] is a					
	two person assis	t with a hoyer. The					
	QMA [indicating	g QMA #1] may have					
	had trouble man	euvering him by herself."					
	What was the ou	_					
		It was not malicious, it					
		d intentional. He never					
		t want her to care for					
		has cared for him since					
		Then informed that RN					
		en interviewed "[Name of					
	_	and yelled that is when soom and Resident #143					
		being rough [indicating					
	Said that She Was	comprought indicating					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D7PL11

Facility ID: 000007

If continuation sheet

Page 15 of 43

PRINTED: 10/20/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155019	B. WIN			09/16/	2014
NAME OF I			•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	X.		1100 S	CURRY PK		
GARDEN VILLA - BLOOMINGTON				BLOOM	IINGTON, IN 47403		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		DON indicated, "She did					
	not tell me that."						
	On 9/10/14 at 11						
	Administrator pr	rovided policy					
	"Abuse/Elder Al	ouse Act Policy" revised					
	date March 2004	I, and indicated that was					
	the policy currer	ntly used by the facility.					
	The policy indic	ated, "These are					
	different types o	f abuse:Catastrophic					
	reactions-extraordinary reactions by a						
		linary stimuli, such as					
		oonse may be weeping,					
		Any complainants of					
	abuse by a reside						
	1	lressed by the nurse on					
	1	ern/Suggestion form on					
	_	ident The staff will					
	_	precautions to assure the					
	_	cted from any further					
		le the report is being					
		h as staff suspension,					
	separating reside						
		eial service will visit the					
		s for psychosocial needs.					
		nitial report forms need to					
	be initiated by the	ne staff nurse, the					
	Administrator ar	nd Director of Nursing					
	should be notified	ed immediately and will					
	begin the report	to the State Board of					
	Health,if no b	odily injury has occurred					
		e sent within 24 hours,					
	_	resident has the right to					
	be free from mis						
		<u> </u>					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D7PL11 Facility ID: 000007

If continuation sheet Page 16 of 43

PRINTED: 10/20/2014 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155019		A. BUILDING B. WING	COMPLETED 09/16/2014				
	ROVIDER OR SUPPLIER VILLA - BLOOMINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN 47403				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF I (EACH DEFICIENCY MUST BE PR REGULATORY OR LSC IDENTIFYI	RECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
	reporting by staff to the RN and/or the administrator must immediately as the incident immediately," 3.1-28(a)	st occur has occurred					
F000225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ inchave been found guilty of abus neglecting, or mistreating resid court of law; or have had a find into the State nurse aide regist abuse, neglect, mistreatment or misappropriation of their properany knowledge it has of actions law against an employee, which indicate unfitness for service as or other facility staff to the State registry or licensing authorities.	ing, ents by a ing entered ry concerning f residents or rty; and report s by a court of h would s a nurse aide e nurse aide					
	violations involving mistreatme abuse, including injuries of unk and misappropriation of resider	nt, neglect, or nown source					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D7PL11

Facility ID: 000007

If continuation sheet Page 17 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETE			ETED	
		155019	B. WING			09/16/	2014
			D. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	8			CURRY PK		
GARDEN VILLA - BLOOMINGTON				MINGTON, IN 47403			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	-	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	are reported imme	•					
		ne facility and to other					
		ance with State law ed procedures (including to					
		and certification agency).					
	line otate survey t	and certification agency).					
	The facility must h	nave evidence that all					
	alleged violations						
	•	must prevent further					
	potential abuse while the investigation is in progress. The results of all investigations must be						
	reported to the administrator or his designated representative and to other						
		ance with State law					
	(including to the S	State survey and					
		cy) within 5 working days of					
		f the alleged violation is					
		te corrective action must					
	be taken.		F000	22.5	F225 It is the policy of Corden		10/12/2014
		ew and record review,	F000	225	F225 It is the policy of Garden Villa to ensure that all alleged	l	10/13/2014
	_	d to ensure an occurrence			violations involving mistreatme	ent.	
	of resident mistr	reatment was immediately			neglect, or abuse,including	,	
	reported to the a	dministrator of the			injuries of unknown source an	d	
	facility or other	officials as indicated by			misappropriation of resident		
		use policy for 1 of 1			property be reported immedia	-	
		ewed for an allegation of			to the required authorities.		
		Resident #143) (RN #3,			What corrective action(s) will be accomplished for those reside		
	QMA#1)	100.00.00.00.00.00.00.00.00.00.00.00.00.			found to have been affected b		
	Αινιστή				the deficient practice; The QN	•	
	F: 1: : 1 1				in question no longer provides		
	Findings include	··			care for Resident #143, thoug	h	
	Resident #143's clinical record was				Resident #143 has verbalized	he	
					welcomed the interaction and	_	
	reviewed on 9/1	2/14 at 1:43 p.m.			care from QMA#1. A careplar was held with Resident #143		
	Diagnoses inclu	ded, but were not limited			the POA. Both agree that they		
	to: anxiety, depr	ession with suicidal			feel that Resident #143 is safe		
		ibrillation (irregular heart			our care and have no concern		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D7PL11

Facility ID: 000007

If continuation sheet Page 18 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 00		COMPLETED	
		155019	A. BUII B. WIN			09/16/2014
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEI	R			CURRY PK	
CADDEN	IVIIIA BLOOMIN	JCTON			MINGTON, IN 47403	
GARDEN VILLA - BLOOMINGTON			BLOOM			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	(X5)	
PREFIX	•	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE
		nsion, insomnia, and			about his well being beyond h	
	osteoarthritis.				cognitive impairment. 2) Ho other residents having the	W
					potential to be affected by the	<u> </u>
	The current MD	S (Minimum Data Set)			same deficient practice will be	
	assessment date	d 7/30/14, indicated a			identified and what corrective	
		erview Mental Status)			action(s) will be taken All	
	`	When 8-15 indicated			residents have the potential to	
					affected by abuse. Inservice v	vas
		vas cognitively intact and			given regarding abuse and reporting. All facility staff were	
	interviewable.				required to read and sign the	
					training provided. This trainin	a
		p.m., interview with the			specifically details the	
	Administrator in	ndicated, "Allegation of			timeframe requirements for	
	abuse came up,	[Name of Resident			reporting. See attached #1.	
	#143], and QMA	A #1. I can not tell you			3) What measures will be put	l l
		ing I walked down the			place or what systemic chang	
	· ·	CNA bumped me into the			will be made to ensure that the deficient practice does not rec	
	· ·	itely called the QMA			Upon hire, criminal history che	
		#1] she indicated, "The			and drug testing are done,	
		_			dementia and abuse training i	s
		, and the resident was			completed and at least annua	lly
	mad about it. T				thereafter. All staff have been	
		#3]. When I asked			educated on what abuse looks	
	-	ent #143] if she did it			like and signs and symptoms staff burnout. The process for	UI
	intentionally he	said, "She did not			shift report has changed to ha	ve
	intentionally do	it ,she apologized to me."			licensed staff report information	
	When I went ba	ck to him he said that he			about resident change in	
	did not feel like	the CNA [QMA #1] did			condition to the CNAs and	
		d it was an accident. I			needed change in intervention	l l
		iter and explained to her			their care. This process will be	
		ated that again [indicating			more proactive approach vers reactive. 4) How the correct	l l
	_				action(s) will be monitored to	
	speaking about the incident with QMA #1]. He said that, 'she put him on the				ensure the deficient practice v	vill
					not recur, i.e., what quality	
		that watched said that it			assurance program will be pu	t
		morning care was being			into place. In addition to our	
	provided, he wa	s already in bed."			current Quality Assurance	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D7PL11

Facility ID: 000007

If continuation sheet

Page 19 of 43

PRINTED: 10/20/2014 FORM APPROVED OMB NO. 0938-0391

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155019	B. WIN			09/16/2014	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1100 S	CURRY PK		
GARDEN VILLA - BLOOMINGTON			BLOOM	IINGTON, IN 47403	_		
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION		
TAG	REGULATORY OR	LSC IDENTIFY ING INFORMATION)		IAG	·	DATE	
TAG	On 9/16/14 at 11 RN #3 indicated tell me about the #143. "I was in t door passing me yelling at her [N really did not see could hear. So I was upset with the said that she was and he was mad she was going to one side to other never seen her be recall what time "In in the morning check around 5 chappened what deremember filing calmed down. In [Name of the DC What is the abus suppose to notify want to say 24 here.]	:35 a.m., interview with when asked if she could incident with Resident he hallway outside of dicine. I heard him ame of QMA #1]. It what was going on but I went in the room and he he CNA [QMA #1]. He is being rough with him What I heard was that have to roll him from to change him. I have being mean." Do you this incident happen? In with her last bed or 6.[a.m.]." After that lid you do? "I don't a complaint cause he remember talking to ON] shortly after that." I don't a protocol? "You are you that's not right, ely. I don't consider that was abusing her." Can lifferent types of abuse?		TAG	program, daily, administrative staff will verify any changes in resident care interventions have been updated on CNA assignment sheets and Care Plans and communicated to fix staff. Monthly this report will be included in the QA program. A 3 months, this process will be reviewed for a scheule change no concerns found. ADDENDUM: While Garden Villa has a Chain of Command, in this circumstance we train staff to follow the guidelines set forth in the Elde Abuse Act stating: "Each employee, agent, contractor, manager, owner, or operator of this facility is individually responsible to report the reasonable suspicion of a crimagainst a resident" The education was clarified to explication was clarified to explication will be done to determine outcome. All allegations will be reported to the staff that suspicion is all they need to report and the investigation will be reported to staff working all shifts. 5) By what date the systemic change will be completed. October 13 2014	DATE //e DOT e fiter e if e the ain the // es	
	any of those thin	cally, emotionally." Did gs happen to him lent #143]? "Not that I					
		-					
		Resident #143 at any time					
		ng this incident? "Not					
	that I know of, th	nere was plenty of room	L				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D7PL11

Facility ID: 000007

If continuation sheet Page 20 of 43

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2			ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
		155019	B. WIN			09/16/2014	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF			1100 S	CURRY PK		
GARDEN VILLA - BLOOMINGTON		_		MINGTON, IN 47403		_	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG		,		TAG			DATE
	for him not to hi	t the wan.					
	Thomas versa marina	aidant nanant aananlatad					
		cident report completed					
	· ·	was the Administrator,					
		nurse immediately					
	,	#1 was not sent home					
	'	ion from Resident #143,					
	as indicated by t	he Director of Nursing.					
	Review of "State	e Agency Unusual					
		ort" dated October 8,					
		by the facility, indicated					
		is an assist of 2 and full					
	1	fer[Name of Resident					
		ed on 10/4/13 that he felt					
	a [nurse] was ro						
	_	on investigation it was					
		nember that the resident					
		ame of QMA #1].					
		#1] was changing [Name					
	of Resident #143						
	breakfast. [Nan	ne of Resident#143] is an					
	assist of 2 and fu	all body lift to transfer.					
	[Name of QMA	#1] was rolling [Name of					
	Resident #143] o	over in bed alone because					
	[Name of Reside	ent 143] is a large man he					
		ult to position. A nurse					
] was in the hall outside					
	-	ent #143] room and heard					
	l =	#1] inform resident of					
	` `	s being done and asked					
		ent #143] to assist in					
	-	ame of RN #3] denied					
	1 -	one or behavior on [Name					
	any mancious to	THE OF DEHAVIOR OIL [INAILIC					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D7PL11 Facility ID: 000007

If continuation sheet Page 21 of 43

PRINTED: 10/20/2014 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION OF CORRECTION 155019	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 09/16/2014			
	PROVIDER OR SUPPLIER N VILLA - BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN 47403					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION			
	of QMA #1] part and [name of resident #143] had no complaints or distress at that time. [Name of QMA #1] denied there being any problems with [Name of Resident #143] at any time. [Name of Resident #143] has asked to withdraw the complaint after voicing the initial concern, stating there isn't any problems. She's been nice to me since and I don't want anyone to get in trouble." On 10/5/13 there was documentation of a phone conversation with the DON and RN #3 regarding the incident with Resident #143 which took place on 9/28/14. This was 7 days after the incident occurred. On 9/16/14 at 12:50 p.m., interview with the DON indicated, "The incident happened on September 28, of 2013, and [Name of Resident #143] reported it October 04, 2013. I think his daughter was visiting and she told us." When asked when did RN #3 report it to you? "I talked to her [indicating RN#3] on October 05, 2013. We made sure that [Name of QMA#1] was not working while we did our investigation." Did [Name of RN #3] call you? "When on the 28th? No, because he didn't complained or yell out about the QMA [QMA #1] so she [indicating RN #3]						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D7PL11

Facility ID: 000007

If continuation sheet

Page 22 of 43

PRINTED: 10/20/2014 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	ION	COMPLE	TED
	155019	B. WING		09/16/2	014
	PROVIDER OR SUPPLIER N VILLA - BLOOMINGTON	STREET ADDRESS, 1100 S CURRY BLOOMINGTON			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX (EACH	ROVIDER'S PLAN OF CORRECTION I CORRECTIVE ACTION SHOULD BI REFERENCED TO THE APPROPE DEFICIENCY)	E	(X5) COMPLETION DATE
	didn't talk to me until the 5th when I called her. [Name of Resident #143] is a two person assist with a hoyer. The QMA [QMA #1] may have had trouble maneuvering him by herself." What was the outcome of your investigation? "It was not malicious, it was not abuse and intentional. He never said that he didn't want her to care for him. In fact she has cared for him since the incident." When informed that RN #3 indicated when interviewed "[Name of Resident #143] had yelled, that is when she entered the room and Resident #143 said that she was being rough [indicating QMA #1]. The DON indicated, "She did not tell me that." On 9/10/14 at 11:00 a.m., the Administrator provided policy "Abuse/Elder Abuse Act Policy" revised date March 2004, and indicated that was the policy currently used by the facility. The policy indicated, "These are different types of abuse: Catastrophic reactions-extraordinary reactions by a resident over ordinary stimuli, such as basic care. Response may be weeping, anger, agitation, Any complainants of abuse by a resident will be immediately addressed by the nurse on duty and a Concern/Suggestion form on behalf of the resident The staff will take immediate precautions to assure the				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D7PL11

Facility ID: 000007

If continuation sheet

Page 23 of 43

PRINTED: 10/20/2014 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155019		A. BUILDING B. WING	00 	COMPLETED 09/16/2014		
	ROVIDER OR SUPPLIER VILLA - BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN 47403				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
	resident is protected from any further abusive acts while the report is being investigated, such as staff suspension, separating residents or increased observation. Social service will visit the resident to assess for psychosocial needs While these initial report forms need to be initiated by the staff nurse, the Administrator and Director of Nursing should be notified immediately and will begin the report to the State Board of Health,if no bodily injury has occurred the report will be sent within 24 hours, Abuse Every resident has the right to be free from mistreatment, All reporting by staff to the RN on call and/or the administrator must occur immediately as the incident has occurred the investigation must being immediately,"					
F000226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D7PL11

Facility ID: 000007

If continuation sheet Page 24 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMI			COMPL	LETED
		155019				09/16	/2014
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R					
CABDE	N VILLA - BLOOMIN	NGTON	1100 S CURRY PK				
	VILLA - DLUUIVIII	NGTOIN		BLOOMINGTON, IN 47403			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	residents and misappropriation of resident						
	property.				F000 H :- H 1: 10 :	_	10/10/2011
		iew and record review,	F00	0226	F226 It is the policy of Garder		10/13/2014
	the facility faile	d to ensure			Villa to ensure that the facility implements the procedures		
	implementation	of abuse policy and			outlined in the Abuse Policy a	ınd	
	procedure of an	occurance of			immediately informs the		
	mistreatment was immediately reported to the administrator of the facility or other officials as indicated by the abuse policy and procedure for 1 of 1 residents				Administrator or other		
					official. Garden Villa submits	the	
						llowing action as evidence of its	
					commitment to compliance wi	ith	
					regulatory requirements. 1)	L =	
	reviewed for an allegation of				What corrective action(s) will		
	mistreatment. (Resident #143) (RN #3,				accomplished for those reside found to have been affected by		
	QMA#1)				the deficient practice; The QN		
					question no longer provides of		
	Findings include	e:			for Resident #143, though	-	
					Resident #143 has verbalized	l he	
	Resident #1421a	clinical record was			welcomed the interaction and		
					care from QMA#1. A careplar		
		2/14 at 1:43 p.m.			was held with Resident #143		
		ded, but were not limited			the POA. Both agree that they		
	to: anxiety, depi	ression with suicidal			feel that Resident #143 is safe our care and have no concern		
	ideation, atrial f	ibrillation (irregular heart			about his well being beyond h		
	rhythm) hyperte	ension, insomnia, and			cognitive impairment. 2) Ho		
	osteoarthritis.				other residents having the	- -	
					potential to be affected by the	:	
	The current MD	OS (Minimum Data Set)			same deficient practice will be	9	
		,			identified and what corrective		
		d 7/30/14, indicated a			action(s) will be taken All		
	`	terview Mental Status)			residents have the potential to		
	score was 13. V	When 8-15 indicated			affected by abuse. Inservice v	was	
	Resident #143 v	vas cognitively intact and			given regarding abuse and reporting. All facility staff were	۵.	
	interviewable.				required to read and sign the	•	
					training provided. This training	q	
	On 9/12/14 2:40	p.m., interview with the			specifically details the timefra	-	
		* '			requirements for reporting. Se		
		ndicated, "Allegation of			attached #1. 3) What measu		
	abuse came up,	[Name of Resident			will be put into place or what		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	A. BUILDING COMPLETE		ED	
		155019	B. WING 09/16/2014)14
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	t		1100 S	CURRY PK		
GARDEN	VILLA - BLOOMIN	IGTON			IINGTON, IN 47403		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE (COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	#143], and QMA	A #1. I can not tell you			systemic changes will be made		
	dates, one morn	ing I walked down the			ensure that the deficient practi does not recur Upon hire,	ce	
	hall, he said, a C	NA bumped me into the			criminal history checks and dru	ıa İ	
	wall. I immedia	tely called the QMA			testing are done, dementia and		
		#1] she indicated, "The			abuse training is completed ar		
		and the resident was			at least annually thereafter. All		
	mad about it. The				staff have been educated on w		
		#3]. When I asked			abuse looks like and signs and		
		-			symptoms of staff burnout. The process for shift report has	9	
[Name of Resident #143] if she did it intentionally he said, "She did not					changed to have licensed staff	,	
					report information about reside		
intentionally do it ,she apologized to me."					change in condition to the CNA		
When I went back to him he said that he				and needed change in			
did not feel like the CNA [QMA #1] did				interventions in their care. This			
	it on purpose and	d it was an accident. I			process will be a more proactive		
	called the daugh	ter and explained to her			approach versus reactive. 4 How the corrective action(s) w	′ I	
	that he has repea	ated that again [indicating			be monitored to ensure the	"	
	speaking about t	he incident with QMA			deficient practice will not recur	,	
		t, 'she put him on the			i.e., what quality assurance		
	_	that watched said that it			program will be put into place.	In	
		morning care was being			addition to our current Quality		
		s already in bed."			Assurance program, daily, administrative staff will verify a	ınv	
	provided, he was	s aneady in ocu.			changes in resident care	,	
	On 0/16/14 at 11	.25 i			interventions have been updat	ed	
		:35 a.m., interview with			on CNA assignment sheets an		
		, when asked if she could			Care Plans and communicated		
		e incident with Resident			floor staff. Monthly this report		
		he hallway outside of			be included in the QA program After 3 months, this process w		
	door passing me	dicine. I heard him			be reviewed for a scheule cha		
	yelling at her [N	ame of QMA #1]. I			if no concerns	3-	
	really did not se	e what was going on but I			found. ADDENDUM: While		
	could hear. So I	went in the room and he			Garden Villa has a Chain of		
	was upset with t	he CNA [QMA #1]. He			Command, in this circumstanc	e,	
	_	s being rough with him			we train staff to follow the guidelines set forth in the Elde	r	
		What I heard was that			Abuse Act stating :"Each	'	
		have to roll him from			employee, agent, contractor,		
	I siic was going it	mave to foll milli floili	1		. , , , , , , , , , , , , , , , , , , ,		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D7PL11

Facility ID: 000007

If continuation sheet Page 26 of 43

PRINTED: 10/20/2014 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A DUBLING	(X3) DATE SURVEY COMPLETED			
	155019	A. BUILDING B. WING	09/16/2014			
	PROVIDER OR SUPPLIER N VILLA - BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN 47403				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN O PREFIX (EACH CORRECTIVE ACT CROSS-REFERENCED TO TAG DEFICIENCE	ION SHOULD BE COMPLETION THE APPROPRIATE			
	one side to other to change him. I have never seen her being mean." Do you recall what time this incident happen? "In in the morning with her last bed check around 5 or 6.[a.m.]." After that happened what did you do? "I don't remember filing a complaint cause he calmed down. I remember talking to [Name of the DON] shortly after that." What is the abuse protocol? "You are suppose to notify the nurse on call. I want to say 24 hours, but that's not right, I think immediately. I don't consider that abuse. If any he was abusing her." Can you tell me the different types of abuse? "Verbally, physically, emotionally." Did any of those things happen to him [Indicating Resident #143]? "Not that I know of." Did Resident #143 at any time hit the wall during this incident? "Not that I know of, there was plenty of room for him not to hit the wall." There was no incident report completed on 9/28/13, nor was the Administrator, DON or on call nurse immediately notified. QMA #1 was not sent home upon the allegation from Resident #143, as indicated by the Director of Nursing. Review of "State Agency Unusual Occurrence Report" dated October 8, 2013, provided by the facility, indicated "Resident #143 is an assist of 2 and full	manager, owner, of this facility is indiviously responsible to report reasonable suspicition against a resident. Education was clarated to the staff that sust they need to report investigation will be determine outcome allegations will be ISDH. This training staff working all showhat date the system will be completed. 2014	or operator of dually ort the on of a crime ." The ified to explain spicion is all and the e done to e. All reported to the includes all iffs. 5) By emic changes			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D7PL11

Facility ID: 000007

If continuation sheet

Page 27 of 43

PRINTED: 10/20/2014 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	00	(X3) DATE SURVEY COMPLETED			
	155019	A. BUILDING		09/16/2014			
	1	B. WING	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>			
NAME OF I	PROVIDER OR SUPPLIER		CURRY PK				
GARDEN	N VILLA - BLOOMINGTON	BLOOMINGTON, IN 47403					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA				
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE			
	body lift to transfer[Name of Resident						
	#143] has reported on 10/4/13 that he felt						
	a [nurse] was rough on 9/28/13.						
	Addendum upon investigation it was						
	found the staff member that the resident						
	reported was [Name of QMA #1].						
	[Name of QMA #1] was changing [Name						
	of Resident #143] in bed before						
	breakfast. [Name of Resident#143] is an						
	assist of 2 and full body lift to transfer.						
	[Name of QMA #1] was rolling [Name of						
	Resident #143] over in bed alone because						
	[Name of Resident 143] is a large man he						
	is at times difficult to position. A nurse						
	[Name of RN #3] was in the hall outside						
	[Name of Resident #143] room and heard						
	[Name of QMA #1] inform resident of						
	the care that was being done and asked						
	[Name of Resident #143] to assist in						
	rolling over. [Name of RN #3] denied						
	any malicious tone or behavior on [Name						
	of QMA #1] part and [name of resident						
	#143] had no complaints or distress at						
	that time. [Name of QMA #1] denied						
	there being any problems with [Name of						
	Resident #143] at any time. [Name of						
	Resident #143] has asked to withdraw the						
	complaint after voicing the initial						
	concern, stating there isn't any problems.						
	She's been nice to me since and I don't						
	want anyone to get in trouble."						
	On 10/5/13 there was documentation of a						
	phone conversation with the DON and						
	1						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D7PL11

Facility ID: 000007

If continuation sheet

Page 28 of 43

PRINTED: 10/20/2014 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 155019	(X2) MULTIPLE CC	00 	COMPLETED 09/16/2014	
	1550 18	B. WING	DDDDGG GWW		72014
	PROVIDER OR SUPPLIER N VILLA - BLOOMINGTON	1100 S	ADDRESS, CITY, STATE, ZIP CODE CURRY PK IINGTON, IN 47403	3	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	RN #3 regarding the incident with Resident #143 which took place on 9/28/14. This was 7 days after the incident occurred.				
	On 9/16/14 at 12:50 p.m., interview with the DON indicated, "The incident happened on September 28, of 2013, and [Name of Resident #143] reported it October 04, 2013. I think his daughter was visiting and she told us." When asked when did RN #3 report it to you? "I talked to her [indicating RN#3] on October 05, 2013. We made sure that [Name of QMA#1] was not working while we did our investigation." Did [Name of RN #3] call you? "When on the 28th? No, because he didn't complained or yell out about the QMA [QMA #1] so she [indicating RN #3] didn't talk to me until the 5th when I called her. [Name of Resident #143] is a two person assist with a hoyer. The QMA [QMA #1] may have had trouble maneuvering him by herself." What was the outcome of your investigation? "It was not malicious, it was not abuse and intentional. He never said that he didn't want her to care for him. In fact she has cared for him since the incident." When informed that RN #3 indicated when interviewed "[Name of Resident #143]				
	had yelled, that is when she entered the				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D7PL11

Facility ID: 000007

If continuation sheet

Page 29 of 43

PRINTED: 10/20/2014 FORM APPROVED OMB NO. 0938-0391

room and Resident #143 said that she was being rough [indicating QMA #1]. The DON indicated, "She did not tell me that." On 9/10/14 at 11:00 a.m., the Administrator provided policy "Abuse/Elder Abuse Act Policy" revised date March 2004, and indicated that was the policy currently used by the facility. The policy indicated, "These are	AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155019			LDING	NSTRUCTION 00	(X3) DATE COMPL 09/16/	ETED	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Toom and Resident #143 said that she was being rough [indicating QMA #1]. The DON indicated, "She did not tell me that." On 9/10/14 at 11:00 a.m., the Administrator provided policy "Abuse/Elder Abuse Act Policy" revised date March 2004, and indicated that was the policy currently used by the facility. The policy indicated, "These are				1100 S CURRY PK				
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Administrator provided policy "Abuse/Elder Abuse Act Policy" revised date March 2004, and indicated that was the policy currently used by the facility. The policy indicated, "These are		room and Reside was being rough The DON indica	ent #143 said that she [indicating QMA #1].					
different types of abuse: Catastrophic reactions-extraordinary reactions by a resident over ordinary stimuli, such as basic care. Response may be weeping, anger, agitation, Any complainants of abuse by a resident will be immediately addressed by the nurse on duty and a Concern/Suggestion form on behalf of the resident The staff will take immediate precautions to assure the resident is protected from any further abusive acts while the report is being investigated, such as staff suspension, separating residents or increased observation. Social service will visit the resident to assess for psychosocial needs While these initial report forms need to be initiated by the staff nurse, the Administrator and Director of Nursing should be notified immediately and will begin the report to the State Board of Health,if no bodily injury has occurred the report will be sent within 24 hours,		Administrator programmediate precaresident is protect abusive acts white investigated, succeptainty acts white investigated by the Administrator are should be notified begin the report Health,if no be	buse Act Policy" revised 4, and indicated that was htly used by the facility. ated, "These are f abuse: Catastrophic rdinary reactions by a dinary stimuli, such as bonse may be weeping, Any complainants of ent will be dressed by the nurse on ern/Suggestion form on ident The staff will take autions to assure the cted from any further le the report is being th as staff suspension, ents or increased ctal service will visit the ss for psychosocial needs. hitial report forms need to ne staff nurse, the and Director of Nursing ed immediately and will to the State Board of odily injury has occurred					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D7PL11

Facility ID: 000007

If continuation sheet

Page 30 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155019		(X2) MU A. BUIL B. WINC	DING	onstruction 00	(X3) DATE S COMPL 09/16/	ETED	
	OVIDER OR SUPPLIER VILLA - BLOOMIN		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN 47403				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F000323 SS=D	be free from mist reporting by staff and/or the admin immediately as the investigation immediately," 3.1-28(a) 483.25(h) FREE OF ACCIDE HAZARDS/SUPEF The facility must environment remain hazards as is possible receives adequate assistance devices Based on observative record review, the residents with his recommended now while in bed for sample of 5 who review of accident (CNA #1) Findings include Resident #115's or reviewed on 9/12	ent to the RN on call istrator must occur the incident has occurred on must being ENT RVISION/DEVICES insure that the resident ins as free of accident supervision and is to prevent accidents. Action, interview, and the facility failed to ensure story of falls wore the on skid socks at all times at 1 of 5 residents in a met the criteria for ints. (Resident #115)	F000	0323	F 323 It is the policy of Garder Villa to ensure that the resident environment remains as free from accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. Garden Villa submit the following action as evidence of its commitment to compliant with regulatory requirements. 1) What corrective action(s) who is accomplished for those residents found to have been affected by the deficient practice. Resident #115 has the intervention for non-skid socks while in bed. The non-skid socks.	t rom e; ssee ce fill	10/13/2014

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D7PL11

Facility ID: 000007

If continuation sheet

Page 31 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. building 00			COMPLETED
		155019	A. BUI B. WIN			09/16/2014
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	₹				
OADDEA	LVIII A DI COMIN	IOTON			CURRY PK	
GARDEN	NVILLA - BLOOMIN	IGTON		BLOOM	MINGTON, IN 47403	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	DATE
	to: hip fracture,	anxiety, history of falls,			were put on resident and no	
	hyperlipidemia.	difficulty walking,			incident or injury occurred. The	
		gait and hyponatremia.			intervention remains in place a	and
		and hyponatienna.			was and is on the assignment	
					sheet. CNA #1 was re-educate	
		S (Minimum Data Set)			on following the assignment shall for any and all resident	ICCI
		d 6/30/14, indicated a			interventions. 2) How oth	er
	BIMS (Brief Interview Mental Status)				residents having the potential	
	was 13, which indicated cognitively				be affected by the same defic	
	intact and interviewable. The MDS				practice will be identified and	
	indicated Resident #115 needed				what corrective action(s) will t	oe e
	extensive assistance of 1 staff member				taken. All residents have the	
					potential to be affected by this	
	for bed mobility, extensive assistance of				deficent practice. All nursing s	
	1 staff for transfer, limited assistance of 2				will been re-educated on the th	
	staff members fo	or walk in room.			importance of following the Ca	
					Plan/Assignment sheets for ea indiviual resident and their	ICH
	Review of nursii	ng notes dated 8/21/14			interventions. See Attached #2	,
		50 p.m. Resident was			3) What measures will be	
		t [Help me] was found			put into place or what systemic	
	_				changes will be made to ensur	
	1	[with] head resting on			that the deficient practice does	
		ated she was sitting on			not recur. Ten random sta	
	edge of bed, wai	ting to go to the		will be audited weekly to verify		
	bathroom & [and	d] she slid to the floor.			staff compliance with resident	. [
	"				specific interventions as outlin	
					on their assignment sheets. So	ee
	Pavian Muraina	note dated 8/25/14			attached. ADDENDUM: This random audit will include all th	ree
	ı				shifts 7/days a week. 4) Ho	
		der Rec'd [received] Non			the corrective action(s) will be	···
	skid socks to be	worn while in bed"			monitored to ensure the deficie	ent
					practice will not recur, i.e., wha	at
	Physician's order	r dated 8/25/14 indicated,			quality assurance program will	be
	-	to be worn while in			put into place. These audits w	rill
	bed."	-			be presented in Quality	
	Jou.				Assurance for 3 months for	
	Camanla :: 1.4. 1.1	10/21/12 for UE			compliance and if no concerns	
	-	10/31/13, for "Functional			will be reviewed for scheduled	
	I Maintenance Pro	ogram: Restorative			change. 5) By what date t	ne

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D7PL11

Facility ID: 000007

If continuation sheet Page 32 of 43

i ´			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155019	B. WIN	G		09/16/2014
NAME OF D	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			1100 S	CURRY PK	
GARDEN VILLA - BLOOMINGTON				IINGTON, IN 47403		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	-	DATE
		ential for decrease in			systemic changes will be completed. October 13, 2014	
		ty due to dx [diagnosis]:			Completed. October 13, 2014	
	HTN (hypertens:	ion), depression, &				
	anxiety Resid	lent will ambulate 75 feet				
	using front whee	el walker and SBA [Stand				
	by Assist] x 7 da	ys a week Ensure				
	proper footwear	is worn PT [Physical				
		at least quarterly"				
	133	1 3				
	Care plan dated 8/22/14, for "Risk for					
	falls characterized by history of					
		tiple risk factors related				
	to:impaired ba					
	coordination, un	• •				
		mobility aide use,				
		requires assist to transfer.				
		Assist resident with				
		sist of :1 staff, call light				
		answer promptly,				
		o call for assistance, low				
	· ·	left alone in room while				
	up,"					
	On 9/15/14 of 1.	10 p.m., Resident #115				
		•				
	1	ing in the bed with feet				
		e side without non skid				
		asked where were the				
		Resident #115 indicated,				
	" Its not on my f	eet."				
	On 9/15/14 at 1::	20 n m CNA #1				
		asked if Resident #115				
		skid socks on while in				
	bed. "No, no one	e ever told me that."				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D7PL11

Facility ID: 000007

If continuation sheet Page 33 of 43

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155019		LDING	NSTRUCTION 00	(X3) DATE COMPI 09/16	ETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN 47403				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE	(X5) COMPLETION DATE
	sheet for Resider what care Resider CNA #1 indicated assignment sheet don't think any of that either [indic socks]." CNA # where her socks indicated, "In the them." Observed non skid socks of drawer and placed CNA #1 indicated told me to put the CNA #1 indicated what intervention fall, LPN #1 indicated what intervention fa	20 p.m., interview with d Resident #115 fell on ame of Resident #115] to of bed. When asked has were put in place after cated, "We have her bocks while in bed and of on low bed."					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D7PL11

Facility ID: 000007

If continuation sheet

Page 34 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S COMPL	
		155019	B. WIN			09/16/	2014
	PROVIDER OR SUPPLIER			1100 S	ddress, city, state, zip code CURRY PK IINGTON, IN 47403		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
IAU	know how to use usually does but asked if anyone and MDS coordinato witness fall. The does have to use frequently." On 9/15/14 at 1: Resident #115 in why were you truthe day you fell? side of the bed help me to the base and both my feet under me." Whe use the call light indicated, "I count asked if the call she have used if indicated, "Yes.' Fall Risk Assess indicated "Hist months] 1-2 F Ambulation/E. Bound-requires a [with] #2, Gain use of assistive of Score above 10 m Resident Educ Low Bed, 8/2:	e the call light and not always." When saw Resident #115 fall, r indicated, "It was not a sy heard her yelling. She the bathroom 10 p.m., interview with idicated, when asked ying to get out of bed on "I was sitting on the ollering for someone to athroom. No one came is just slid right from it asked why didn't she is, Resident #115 idn't reach it." When light was in reach would if Resident #115 imment dated 8/25/14 fory of Falls [past 3 alls in past 3 months #2, limination Status Chair assist assist w/toileting t/Balance Requires levices #1, Total represent HIGH RISK 11 reation: Call Light Use, 5/14: Non Skid Socks to		IAU			DATE
	be worn while in	veu,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D7PL11

Facility ID: 000007

If continuation sheet

Page 35 of 43

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC	00	(X3) DATE SURVEY COMPLETED		
		155019	A. BUILDING B. WING		09/16/2014	
	ROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE CURRY PK MINGTON, IN 47403		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	(X5) COMPLETION DATE	
	Assignment Shedindicated that was care assignment indicated, " [No sock to be worn?] On 9/16/14 at 9:4 provided form la Incorporated, CN Checklist" unda Item of instruction Demonstration, I Reviewed, No H	ame of Resident #115] while in bed," 47 a.m., the DON beled "Continuing Care NA Orientation ted, The form indicated "				
F000371 SS=E	The facility must - (1) Procure food from considered satisfal local authorities; a (2) Store, prepare, under sanitary corn Based on observe record review, the cold food were stemperature indicates and 410 LE Establishment Satisfactories.	E/SERVE - SANITARY om sources approved or ctory by Federal, State or nd distribute and serve food	F000371	F371 It is the policy of Garde Villa to ensure that cold food i stored at the proper temperate and to follow proper sanitation and food handling practices to prevent the outbreak of food bourne illness. 1) What corrective action(s) will be accomplished for those reside	s ure n	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D7PL11

Facility ID: 000007

If continuation sheet

Page 36 of 43

STATEMENT OF DEFICIENCIES				ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LDING	00	COMPLETED	
		155019	B. WIN			09/16/2014	
MANGOTT	DOLUDED OF GUREL TO			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1100 S	CURRY PK		
	VILLA - BLOOMIN		_	BLOOM	MINGTON, IN 47403		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)		TAG	found to have been affected by	DATE	
	measured at 42 d	legrees Fahrenheit.			the deficient practice. Immediately the cold food iter		
	Findings include	:			found beyond the temperature requirement were disposed of		
	On 9/12/14 at 10	:30 a.m., interview with			No other food items were		
		t Shift Supervisor			found outside the food		
		sidents were served from			temperature requirement. No		
	ĺ	Night Shift Supervisor			residents were harmed or serv		
		vere approximately 100			items outside the temperature guideline. 2) How othe		
		ceived puree prepared			residents having the potential		
					be affected by the same defic		
foods, 25 residents rece					practice will be identified and		
	soft prepared for	ds and 56 regular diets.			what corrective action(s) will be	pe	
					taken. All residents have the potential to be affected by time		
		:25 a.m., observed Cook			and temperature abuse (TCS)		
	_	peratures on cold food			The dietary staff was inservice		
	items which were observed sitting out in				regarding temperature, food lii	ne	
	the kitchen for 1 hour. The temperature of the cottage cheese which was in a bowl on a cart was tempted at 49.8 degrees. There was yogurt in a metal pan with temperature of 42 degrees				set-ups and daily auditing. A		
					change in the way the cold ite		
					are being held was implement and timing of items that are ou		
					during service. Potentially		
					hazardous foods or time		
	Fahrenheit. When asked what the temperature should be on cold items, Cook #1 indicated, "Thirty-two to forty-one degrees." The Dietary Aide				temperature control for safety		
					food held in the danger zone f		
					more than 4 hours may cause		
					food bourne illness outbreak i consumed. Any and all TCS	T	
	1 -	_			foods must be discarded prior	to	
		d by the Chef to throw all			the 4th hour. Based on this		
		eese cups that were on			requirement the food items		
	<u> </u>	ne yogurt which were in			discarded were not within the		
	the pan out. D.A. #1 was observed at that				food bourne illness requirement		
	time to remove the	he tray of cottage cheese			range. The kitchen is now wri		
	and pan of yogurt.				of the refrigerator to ensure we		
					meet the time and temperature		
	On 9/12/14 at 12	:15 p.m., the Chef			requirements. 3) What		
	provided documentation labeled "Food				measures will be put into place	e or	

STATEMENT OF DEFICIENCIES X1) PROVIDER/S		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION ID		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED		
155019		A. BUII B. WIN			09/16/2	2014		
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER								
GARDEN	I VILLA - BLOOMIN	IGTON		1100 S CURRY PK BLOOMINGTON, IN 47403				
					111101011, 111 47 400			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA [*] DEFICIENCY)	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG			DATE	
	Safety Information" revised date October				what systemic changes will be			
	2011. The docu	mentation indicated, "		made to ensure that the deficien practice does not recur. All times		I		
	[Danger Zone] [4	40 degree F-140 degree			for all TCS foods will be			
	F] Fahrenheit	Leaving food out too			documented/logged when			
	_	nperature can cause			removed from the refrigerator.			
	_	Staphylococcus aureus.			This Time In/Out log will			
	-	ritis, Escherichia coli			document time items were			
		erous levels that can			removed from refrigerator and			
	-	cteria grow most rapidly			ensure that items prior to the 4 hour are discarded. See attack			
					#3. ADDENDUM: This will	lea		
	_	emperatures between 40			include all three meals 7/days	a		
	degree F and 140 degree F, doubling in number in as little as 20 minutes Keep cold food coldat or below 40 degree F. Place food in containers on				week. 4) How the corrective			
					action(s) will be monitored to			
					ensure the deficient practice w	rill		
					not recur, i.e., what quality			
	ice."				assurance program will be put			
					into place. Daily the log will b reviewed for compliance by the			
	On 9/12/14 at 12	2:15 p.m., the Chef			Chef or his designee. These			
	provided policy	•			logs will be presented monthly	in		
	SAFETY FOOD				Quality Assurance for 3 month			
					and then reviewed for a schde	ule		
		undated and indicated			change if no concerns. 5) I	,		
		currently used by the			what date the systemic change			
		licy indicated, " All			will be completed. October 13 2014	ο,		
	foods are stored	in a safe manner						
	Procedure I. D	Danger zone: temperature						
	range [40 to 140	degrees] in which						
	bacteria and other	er microbes grow rapidly.						
	"							
	On 9/17/14 at 1:03 p.m., review of the 410 IAC 7-24-187 dated November 13, 2004, indicated "Potentially hazardous							
		d holding,[a] Except						
	during preparation, cooking, or cooling,							
	potentially hazardous food shall be							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D7PL11

Facility ID: 000007

If continuation sheet Page 38 of 43

AND PLAN OF CORRECTION IDE		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155019	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/16/2014
			B. WING STREET A	ADDRESS, CITY, STATE, ZIP CODE	00/10/2011
NAME OF F	PROVIDER OR SUPPLIER		1100 S	CURRY PK	
GARDEN	I VILLA - BLOOMIN	GTON	BLOOM	MINGTON, IN 47403	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
		llows:[2] At a eified in the following: [41] degrees Fahrenheit			
F000431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D7PL11

Facility ID: 000007

If continuation sheet

Page 39 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 155019 09/16/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1100 S CURRY PK **GARDEN VILLA - BLOOMINGTON BLOOMINGTON. IN 47403** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. F431 It is the policy of Garden 10/13/2014 F000431 Based on observation, interview, and Villa to ensure that expired record review, the facility failed to ensure medications are disposed of and expired medications were disposed of as stored at the proper temperature. the facility policy indicated and a 1) What corrective action(s) will be accomplished for those medication was stored at the proper residents found to have been temperature in that promethazine affected by the deficient practice. suppositories were not refrigerated as the No residents were affected pharmacy indicated for 3 of 12 by medication cited as no medication expired had been medications carts (Station 3 South administered. 2) How other Middle Cart, Station 1 North medication residents having the potential to cart, Station 3 North #2 medication cart) be affected by the same deficient on 3 of 6 units reviewed for medication practice will be identified and what corrective action(s) will be storage. (Resident #9, Resident #245, taken. All residents have the Resident #246) potential to be affected by this deficient practice. Medication Findings include: carts have been and are being monitored for medication compliance. Any medication On 9/12/2014 at 12:30 p.m., an found will be disposed of and observation of Station 3 South's middle documented per facility policy. All medication cart included the following: promethazine suppositories one vial of Resident #245's nitroglycerine labeled refrigerate are in the refrigerator, despite that the (used for moderate to severe acute medication is stable per the angina/rapid onset of chest pain) 0.4 mg manufacturer guideline not (milligram) vial had been dispensed from refergerated. 3) What the pharmacy on 12/23/2011, the measures will be put into place or what systemic changes will be manufacturer's expiration date was made to ensure that the deficient 8/2014. At that time, an interview with

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D7PL11

Facility ID: 000007

If continuation sheet

Page 40 of 43

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A RUIL DING 00		00	COMPLETED	
		155019	A. BUILDING B. WING			09/16/2014	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					CURRY PK		
GARDEN VILLA - BLOOMINGTON					IINGTON, IN 47403		
GARDEN	I VILLA - BLOOWIIN	GTON		BLOOK	IIING I OIN, IN 47403		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	RN #1 indicated	the nitroglycerine was			practice does not recur. All		
	expired on 8/201	4, and would need to be			licensed staff have been		
	disposed of and	removed it from the		re-educated to verify expiration dates before administering		1	
	medication cart.				medication and medication		
					carts are being audited by nursing		
	On 9/12/2014 at	12:35 n.m. an			adminstration weekly for expire	-	
		tation 3 South's middle			meds. and proper storage. Th	is	
					education has also been adde		
		ncluded the following:			the new nurse orientation for n	ew	
		ondanestron (used for			employees. See attached #4. 4) How the corrective action	(c)	
		ting) 4 mg dispensed			will be monitored to ensure the		
	from the pharma	cy on 8/23/2013, had a			deficient practice will not recur		
	expiration date of 8/23/2014. At that time, an interview with RN #1 indicated the ondanestron was expired and would need to be disposed of and removed it				i.e., what quality assurance	,	
					program will be put into place.		
					Medication carts are being		
					audited by nursing adminstrati	on	
	from the medicar				weekly for expired meds. and		
	nom the medica	tion cart.			proper storage. These audits was be presented in Quality	VIII	
	On 0/12/2014 at	1.00			Assurance for 3 months and the	nen	
	On 9/12/2014 at	•			reviewed for schedule change		
	observation of S				no concerns. 5) By what		
		ncluded the following:			date the systemic changes will		
	an Advair Disku	s (respiratory inhaler			completed. October 13, 2014		
	used for mainten	ance therapy for airflow					
	obstruction in pa	tient with chronic					
	obstructive pulm	onary					
	•	ance of asthma) did not					
		or patient label, the					
		nufacturers expiration					
		-					
	date of 4/2014. At that time, the Station 1 Unit Manager and RN #2 indicated the						
		id not have a pharmacy					
	-	was expired and would					
	be disposed of.						
	An observation of	on 9/12/2014 at 1:15					

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		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155019		A. BUILDING	00	COMPLETED 00/16/2014	
100019			B. WING		09/16/2014
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE CURRY PK	
GARDEN VILLA - BLOOMINGTON				MINGTON, IN 47403	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	1	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	p.m., of Station	3's North Medication cart			
	included the foll	owing: Resident #9's			
	promethazine 25	mg rectal suppositories			
	(used for nausea) dispensed from the			
	pharmacy on 8/1	18/2014. The 6			
	_	ppositories were in the			
	_	e medication cart at room			
	temperature. The				
		ted refrigerate. At that			
	·	lanager for Station 3			
		the suppositories should			
	be refrigerated and would be disposed of.				
	On 0/16/2014 at	12:40 n m on interview			
	On 9/16/2014 at 12:49 p.m., an interview with the pharmacist indicated the pharmacy recommends that promethazine suppositories should be refrigerated for				
	ease of insertion	_			
	ease of insertion rectairy.				
	On 9/15/2014 at	9:03 a.m., the Director			
		ided the Administering			
	0 1	s Protocol, dated			
		, and indicated the policy			
		rently used by the facility.			
	The policy indic	ated:			
	"Steps in the P	Procedure7. Check the			
	expiration date on the medication. Return any expired medications to the pharmacy"				
		1:00 p.m., the Director			
	• •	ided the Preparation and			
	General Guidelines policy, dated 2006,				
	and indicated the policy was the one				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D7PL11

Facility ID: 000007

If continuation sheet Page 42 of 43

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155019 NAME OF PROVIDER OR SUPPLIER			ONSTRUCTION 00 ADDRESS, CITY, STATE, ZIP CODE CURRY PK	(X3) DATE SURVEY COMPLETED - 09/16/2014 DDE				
GARDE	N VILLA - BLOOMII	NGTON	BLOOMINGTON, IN 47403					
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLET	TION		
	policy indicated	on in multidose vials may ne manufacturer's						

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: D7PL11 Facility ID: 000007